INTRODUCTION

The CMS 1500 (formerly HCFA 1500) claim form is used to bill for most non-facility services, including professional services, transportation, and durable medical equipment. Ambulatory surgery centers and independent laboratories also must bill for services using the CMS 1500.

☑ CPT and HCPCS procedure codes must be used to identify all services.

☑ ICD-9 diagnosis codes are required.

- ✓ AHCCCS does not accept DSM-4 diagnosis codes, and behavioral health services billed with DSM-4 diagnosis codes will be denied.

COMPLETING THE CMS 1500 CLAIM FORM

The following instructions explain how to complete the CMS 1500 claim form and whether a field is "Required," "Required if applicable," or "Not required."

NOTE: This chapter applies to paper CMS 1500 claims submitted to AHCCCS. For information on HIPAA-compliant 837 transactions, please consult the appropriate Implementation Guide. Companion documents for 837 transactions are available on the AHCCCS Web site at www.ahcccs.state.az.us. The companion documents are intended to supplement, but not replace, the 837 Implementation Guides for the 837 transaction.

1. Program Block — Required

Check the second box labeled "Medicaid."

MEDICARE	MEDICAID	CHAMPUS	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER
☐ *(Medicare#)*	☒ *(Medicaid#)*	☐ *(Sponsor's SSN)*	☐ *(VA File #)*	☐ *(SSN or ID)*	☐ *(SSN)*	☐ *(ID)*

1a. Insured's ID Number — Required

Enter the recipient's *AHCCCS ID number*. If there are questions about eligibility or the AHCCCS ID number, contact the AHCCCS Verification Unit. (See Chapter 2, Recipient Eligibility and Enrollment). Behavioral health providers must be sure to enter the client's AHCCCS ID number, *not* the client's BHS number.

1a. INSURED'S ID NUMBER	(FOR PROGRAM IN ITEM 1)
A12345678	

COMPLETING THE CMS 1500 CLAIM FORM (CONT.)

2. Patient's Name **Required**

Enter recipient's last name, first name, and middle initial as shown on the AHCCCS ID card.

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

Holliday, John H.

3. Patient's Date of Birth and Sex **Required**

Enter the recipient's date of birth. Check the appropriate box to indicate the patient's gender.

3. PATIENT'S BIRTH DATE SEX

MM DD YY

08 | 14 | 1851 M ☒ F ☐

4. Insured's Name **Not required**

5. Patient Address **Not required**

6. Patient Relationship to Insured **Not required**

7. Insured's Address **Not required**

8. Patient Status **Not required**

9. Other Insured's Name **Required if applicable**

If the recipient has no coverage other than AHCCCS, leave this section blank. If other coverage exists, enter the name of the insured. If the other insured is the recipient, enter "Same."

9a. Other Insured's Policy or Group Number **Required if applicable**

Enter the group number of the other insurance.

9b. Other Insured's Date of Birth and Sex **Required if applicable**

If the other insured is not the AHCCCS recipient, enter the month, day, and year (MM/DD/YYYY) of the other insured's birth. Check the appropriate box to indicate gender.

COMPLETING THE CMS 1500 CLAIM FORM (CONT.)

9c. Employer's Name or School Name **Required if applicable**

Enter the name of the organization, such as an employer or school, which makes the insurance available to the individual identified in Field 9.

9d. Insurance Plan Name or Program Name **Required if applicable**

Enter name of insurance company or program name that provides the insurance coverage.

10. Is Patient's Condition Related to: **Required if applicable**

Check "YES" or "NO" to indicate whether the patient's condition is related to employment, an auto accident, or other accident. If the patient's condition is the result of an auto accident, enter the two-letter abbreviation of the state in which the person responsible for the accident is insured.

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (CURRENT OR PREVIOUS)

☒ YES ☐ NO

b. AUTO ACCIDENT? PLACE (State)

☐ YES ☒ NO [ ]

c. OTHER ACCIDENT?

☐ YES ☒ NO

11. Insured's Group Policy or FECA Number **Required if applicable**

11a. Insured's Date of Birth and Sex **Required if applicable**

11b. Employer's Name or School Name **Required if applicable**

11c. Insurance Plan Name or Program Name **Required if applicable**

11d. Is There Another Health Benefit Plan **Required if applicable**

Check the appropriate box to indicate coverage other than AHCCCS. If "Yes" is checked, you must complete Fields 9a-d.

12. Patient or Authorized Person's Signature **Not required**

13. Insured's or Authorized Person's Signature **Not required**

COMPLETING THE CMS 1500 CLAIM FORM (CONT.)

14. Date of Illness or Injury — **Required if applicable**

15. Date of Same or Similar Illness — **Not required**

16. Dates Patient Unable to Work in Current Occupation — **Not required**

17. Name of Referring Physician — **Required if applicable**
17a. ID Number of Referring Physician

Required only for podiatry services.

18. Hospitalization Dates Related to Current Services — **Not required**

19. Reserved for Local Use — **Not required**

20. Outside Lab — **Not required**

21. Diagnosis Codes — **Required**

Enter at least one *ICD-9 diagnosis code* describing the recipient's condition. Behavioral health providers must **not** use DSM-4 diagnosis codes. Up to four diagnosis codes in priority order (primary condition, secondary condition, etc.) may be entered.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)	
1. | 250 . 52	3. | _____ . _____
2. | _____ . _____	4. | _____ . _____

22. Medicaid Resubmission Code — **Required if applicable**

Enter the appropriate code ("A" or "V") to indicate whether this claim is a resubmission of a denied claim, an adjustment of a paid claim, or a void of a paid claim. Enter the AHCCCS Claim Reference Number (CRN) of the denied claim being resubmitted or the paid claim being adjusted or voided in the field labeled "Original Reference No."

See Chapter 4, General Billing Rules, for information on resubmissions, adjustments, and voids.

22. MEDICAID RESUBMISSION CODE	ORIGINAL REF. NO.
A	030010004321

COMPLETING THE CMS 1500 CLAIM FORM (CONT.)

23. Prior Authorization Number **Not required**

The AHCCCS claims system automatically searches for the appropriate authorization for services that require authorization. See Chapter 8, Authorizations/IHS Referrals, for information on prior authorization.

24A. Date of Service **Required**

Enter the beginning and ending service dates.

24. A						B	C	D	
DATE(S) OF SERVICE						Place	Type	PROCEDURE, SERVICES, OR SUPPLIES	
From			To			of	of	(Explain Unusual Circumstances)	
MM	DD	YY	MM	DD	YY	Service	Service	CPT/HCPCS	MODIFIER
03	15	03	03	30	03				

24B. Place of Service **Required**

Enter the two-digit code that describes the place of service.

03	School	22	Outpatient Hospital	54	ICF/Mentally Retarded
04	Homeless shelter	23	ER - Hospital	55	Residential Substance Abuse Treatment Facility
05	IHS Free-standing Facility	24	ASC	56	Psych Residential Treatment Center
06	IHS Provider-based Facility	25	Birthing Center	57	Non-residential Substance Abuse Treatment Facility
07	Tribal 638 Free-standing Facility	26	Military Treatment Facility	60	Mass Immunization Center
08	Tribal 638 Provider-based Facility	31	Skilled Nursing Facility	61	Comprehensive Inpatient Rehabilitation Facility
11	Office	32	Nursing Facility	62	Comprehensive Outpatient Rehabilitation Facility
12	Home	33	Custodial Care Facility	65	ESRD Treatment Facility
13	Assisted Living Facility	34	Hospice	71	Public Health Clinic
14	Group Home	41	Ambulance – Land	72	Rural Health Clinic
15	Mobile Unit	42	Ambulance – Air or Water	81	Independent Laboratory
20	Urgent Care Facility	49	Independent Clinic	99	Other Place of Service
21	Inpatient Hospital	50	FQHC		
		51	Inpatient Psych Facility		
		52	Psych Facility - Partial Hospitalization		
		53	Community Mental Health Center		

24. A						B	C	D	
DATE(S) OF SERVICE						Place	Type	PROCEDURE, SERVICES, OR SUPPLIES	
From			To			of	of	(Explain Unusual Circumstances)	
MM	DD	YY	MM	DD	YY	Service	Service	CPT/HCPCS	MODIFIER
						11			

COMPLETING THE CMS 1500 CLAIM FORM (CONT.)

24C. Type of Service **Not required**

24D. Procedure and Procedure Modifier **Required**

Enter the CPT or HCPCS procedure code that identifies the service provided. If the same procedure is provided multiple times on the *same date of service*, enter the procedure only once. Use the Units field (Field 24G) to indicate the number of times the service was provided on that date. Unit definitions must be consistent with the HCPCS and CPT manuals.

For some claims billed with CPT/HCPCS codes, procedure modifiers must be used to accurately identify the service provider and avoid delay or denial of payment. If more than two modifiers are required to completely delineate the service provided, enter "99" as the first modifier, then list the modifiers being billed with the procedure code. Call Claims Customer Service to verify that a modifier is valid for a procedure code.

24. A						B	C	D	
DATE(S) OF SERVICE						Place	Type	PROCEDURE, SERVICES, OR SUPPLIES	
From			To			of	of	(Explain Unusual Circumstances)	
MM	DD	YY	MM	DD	YY	Service	Service	CPT/HCPCS	MODIFIER
								71010	26

24E. Diagnosis **Required**

Relate the service provided to the diagnosis code(s) listed in Field 21 by entering the *number* of the appropriate diagnosis. Enter only the reference number from Field 21 (1, 2, 3, or 4), *not* the diagnosis code itself. If more than one number is entered, they should be in descending order of importance.

D		E	F	G	H
PROCEDURE, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		DIAGNOSIS	$ CHARGES	DAYS OR	EPSDT Family
CPT/HCPCS	MODIFIER	CODE		UNITS	Plan
		1			
		1, 2			

COMPLETING THE CMS 1500 CLAIM FORM (CONT.)

24F. Charges **Required**

Enter the total charges for each procedure. If more than one unit of service was provided, enter the total charges for all units. For example, if each unit is billed at $50.00 and three units were provided, enter $150.00 here and three units in Field 24G.

D		E	F	G	H
PROCEDURE, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	DIAGNOSIS CODE	$ CHARGES	DAYS OR UNITS	EPSDT Family Plan
			150 00		
			79 00		

24G. Units **Required**

Enter the units of service provided on the date(s) in Field 24A. Bill all units of service provided on a given date on one line. Unit definitions must be consistent with CPT and HCPCS manuals.

D		E	F	G	H
PROCEDURE, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	DIAGNOSIS CODE	$ CHARGES	DAYS OR UNITS	EPSDT Family Plan
				2	
				1	

24H. EPSDT/Family Planning **Not required**

24I. Emergency **Required if applicable**

Mark this box with a "✓," an "X," or a "Y" if the service was an emergency service, regardless of where it was provided.

E	F	G	H	I	J	K
DIAGNOSIS CODE	$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	EMG	COB	RESERVED FOR LOCAL USE
				✓		

COMPLETING THE CMS 1500 CLAIM FORM (CONT.)

24J. COB **Required if applicable**

Check this box for coordination of benefits if there is Medicare or other insurance coverage for the services billed on this line.

E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
					✓	

24K. Reserved for Local Use **Required if applicable**

Use this field to report Medicare and/or other insurance information. For Medicare, enter the Coinsurance and Deductible amounts. If a recipient's Deductible has been met, enter zero (Ø) for the Deductible amount.

For recipients and services covered by a third party payer, enter only the amount *paid*.

Always attach a copy of the Medicare or other insurer's EOB to the claim.

If the recipient has Medicare coverage but the service is not covered by Medicare or the provider has received no reimbursement from Medicare, the provider should "zero fill" Field 24K. Leaving the field blank will cause the claim to be denied.

See Chapter 9, Medicare/Other Insurance Liability, for details on billing claims with Medicare and other insurance.

E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
						175 / 0

COMPLETING THE CMS 1500 CLAIM FORM (CONT.)

25. Federal Tax ID **Required**

Enter the tax ID number and check the box labeled "EIN." If the provider does not have a tax ID, enter the provider's Social Security Number and check the box labeled "SSN."

25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT ACCOUNT NO.
86-1234567	☐	☑	

26. Patient Account Number **Required if applicable**

This is a number that the provider has assigned to uniquely identify this claim in the provider's records. AHCCCS will report this number in correspondence, including the Remittance Advice, to provide a cross-reference between the AHCCCS CRN and the provider's own accounting or tracking system.

27. Accept Assignment **Not required**

28. Total Charge **Required**

Enter the total for all charges for all lines on the claim.

27. ACCEPT ASSIGNMENT? (For govt claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
☐ YES ☐ NO	$ 179 00	$	$

29. Amount Paid **Required if applicable**

Enter the total amount that the provider has been paid for this claim by all sources *other than AHCCCS*. Do *not* enter any amounts expected to be paid by AHCCCS.

30. Balance Due **Not required**

COMPLETING THE CMS 1500 CLAIM FORM (CONT.)

31. Signature and Date **Required**

The claim must be signed by the provider or his/her authorized representative. Rubber stamp signatures are acceptable if initialed by the provider representative. Enter the date on which the claim was signed.

31. SIGNATURE OF PHYSICIAN OR SUPPLIER
INCLUDING DEGREE OR CREDENTIALS
(I certify that the statements on the reverse
apply to this bill and are made a part thereof.)

SIGNED John Doe DATE 03/01/03

32. Name & Address of Facility Where Services Were Rendered **Required if applicable**

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)

Arizona Hospital
123 Main Street
Scottsdale, AZ 85252

33. Provider Name, Address and Phone **Required**

Enter the provider name, address, and phone number. If a group is billing, enter the group biller's name, address, and phone number.

Enter the *service* provider's six-digit *AHCCCS provider ID number* and two-digit locator code next to "PIN #." Do not enter more than two digits for locator code. Behavioral health providers must **not** enter their BHS provider ID number.

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Doc Holliday
123 OK Corral Drive
Tombstone, AZ 85999

PIN # 123456 01 | GRP #

COMPLETING THE CMS 1500 CLAIM FORM (CONT.)

33. Provider Name, Address and Phone (Cont.) **Required**

If a group is billing, enter the *service* provider's six-digit AHCCCS provider ID and two-digit locator code next to "PIN #." Enter the *group biller ID* in the "GRP#" field.

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

XYZ Billing Agency
123 Easy Street
Carefree, AZ 89999

PIN # 123456 01 | GRP # 654321